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ABSTRACT

Intended for parents, the booklet focuses on the speech and language development of children with language delays. The following topics are among those considered: the parent's role in the initial diagnosis of deafness, intellectual handicap, and neurological difficulties; diagnoses and single causes of difficultiy with speech; what to say to professionals and neighbors; significant behaviors of a language disordered child; preliminary exercises for developing speech; expressive language; articulation problems; and children with special language problems (stuttering, cleft palate, cerebral palsy, mental retardation, and emotional disturbance). A final section touches upon relationships with other children and adults. (CL)

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AUSTRALIAN EARLY CHILDHOOD RESOURCE BOOKLETS

No. 4 1980

TEACHING SPEECH TO YOUR LANGUAGE DELAYED CHILD

by Roger J. Rees

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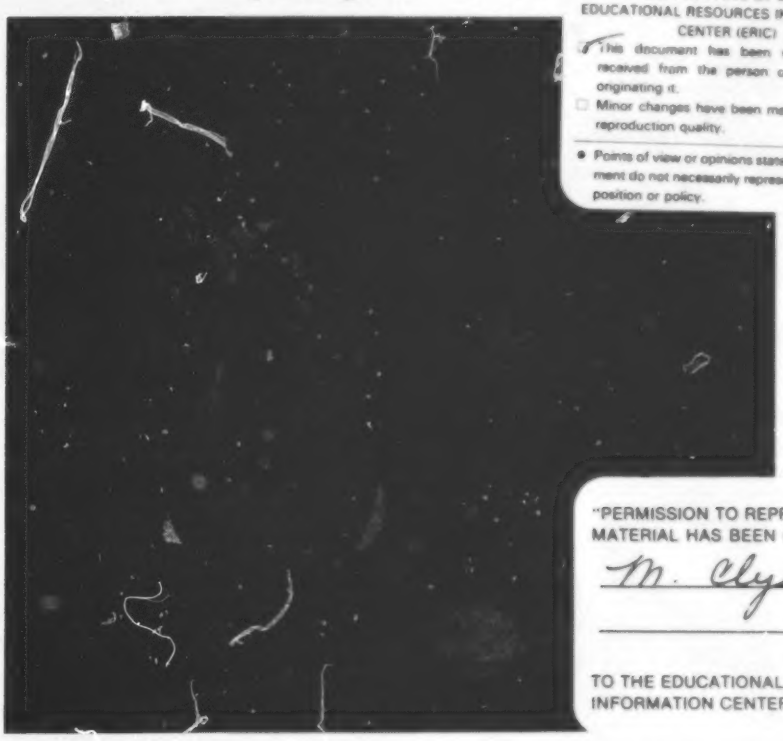

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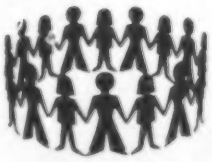

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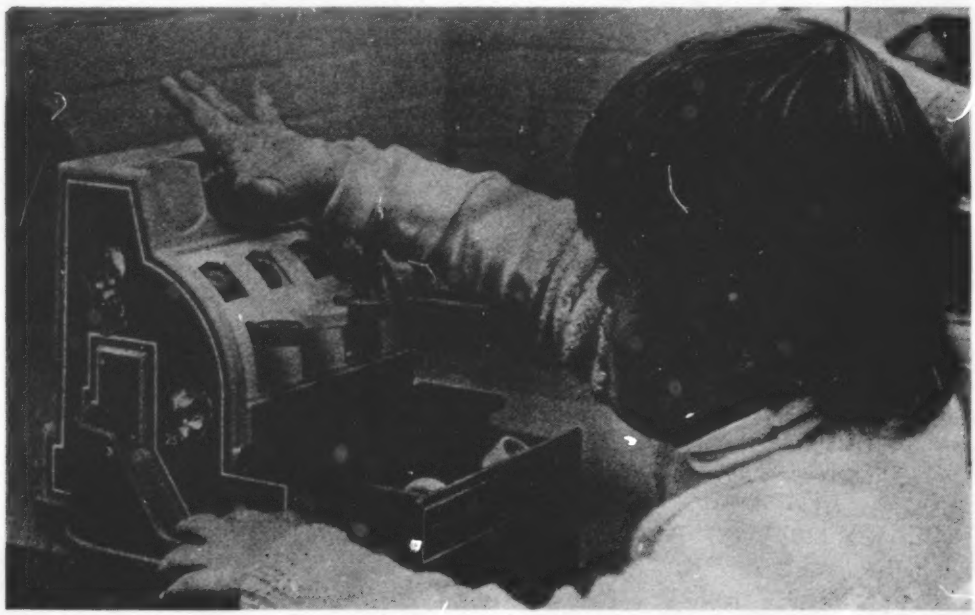

INTRODUCTION

Although most children learn their native language in a relatively short period of time and without instruction, there are other children who have considerable difficulty. These children learn language only with much help or they only acquire a very limited language. They are the concern of their parents, teachers, speech therapists, physiotherapists, audiologists and specialists in psychology and medicine. The speech and language development of these children is the focus of this booklet.

THE ROLE OF PARENTS AND THE INITIAL DIAGNOSIS

When parents are worried about their children's speech, they should discuss their concerns with the family doctor, or pre-school teacher or consultant or if possible with a speech therapist. The aim of any initial diagnosis is to establish whether a child's problem with speech is due to (a) deafness, (b) intellectual handicap or mental retardation or (c) to some more specific central neurological difficulties.

(a) DIAGNOSIS OF DEAFNESS

If the doctor is suspicious of deafness, he will refer the child to the Department of Audiology of the local Health Centre or to the Ear Nose and Throat Department of the local hospital. At the Health Centre or hospital a careful test of the child's hearing can be carried out. Some children can have a mild hearing loss and this can impair speech. Some children can have a mild hearing loss of a temporary nature (due for example to a middle ear infection) and this can impair speech especially if the infection occurs at a vital stage in development. Some children may have a more severe hearing loss and this will mean that the child will have to wear a hearing aid. In this child's case, he or she may require special education by a teacher of the deaf.

(b) DIAGNOSIS OF INTELLECTUAL HANDICAP

If a child's hearing is normal, but his or her speech development is quite delayed, then intellectual handicap could be the cause. For example, if a child's development of skills in standing, walking, toileting, using hands and fingers are all proceeding at a considerably slower rate than normal, then some degree of intellectual handicap could be suspected. If the child's speech development seems parallel with the other skills, then parents ought to seek further advice in dealing with the more fundamental problem of intellectual handicap. However, if the speech development is more retarded than the other developing skills, then further diagnosis and help from teachers and speech therapists is required. Sometimes a child's speech difficulties are not noticed until he goes to pre-school. The child may not have talked to many people before this, with the result that parents may not have been aware that there was much wrong with the child's speech. This lack of awareness by parents of just how delayed a child's speech is, occurs much more often with a first born child.

(c) DIAGNOSIS OF NEUROLOGICAL DIFFICULTIES OR DAMAGE

It seems natural to many parents to look into their child's mouth and search there for some irregularity to account for the speech difficulty. This can be like examining the wheels or the steering or the accelerator rather than a car's engine to find out just why a car does not move. Thus while the inability of a child to speak **may** be caused by defects to the lips, teeth, tongue, hard palate, soft palate or larynx it is more likely to arise from something wrong or undeveloped in the workings of the brain. It is not possible to examine the brain to see what is wrong. However, careful observation and examination of a child's unusual behaviour may indicate whether there is a lack of development or injury to the brain. For example, some lack of development or injury to the brain may cause the incoming messages to be distorted so that a child in effect does not hear them properly. Alternatively damage or injury to the speech motor area of the brain may cause lack of control over the tongue or the larynx (vocal chords).

The individual movements of the speech organs must all be co-ordinated into a highly complex pattern that will produce the sounds that we recognise as the words of our language. Sometimes children are able to move each of the individual speech organs in the required manner (imitation skills with the tongue or adequate soft palate movements), yet they fail to produce normal speech. This is because these children cannot co-ordinate the movement of the speech organs (tongue tip, jaws, soft palate), or do so at the speed of conversational speech. Most typical of these, are children with cerebral palsy. These children can often give one or maybe two word answers with clarity, yet they slur and drawl longer utterances so that they are unintelligible.

DIAGNOSES AND SINGLE CAUSES OF DIFFICULTY WITH SPEAKING

Despite the prevalence of mental retardation, profound deafness or paralysis of the speech organs as causes of difficulty with speaking, there is generally much overlap and seldom a single cause. It is most important not to jump to some eye catching defect, such as supposed poor tongue control as the cause of speech disorder. Rather, a comprehensive diagnosis should be sought as **soon** as possible. Indeed parents, teachers and speech therapists should be concerned to develop a child's speech and language related skills as early in life as possible. This should be undertaken regardless of the causes of the difficulties.

WHAT TO SAY TO THE DOCTOR, TEACHER, SPEECH THERAPIST OR NEIGHBOUR

A recurring problem for parents is how to describe the child's inability to speak. It should be realised that there is currently no agreement on the definition of the terms used to describe the child who is not learning to speak normally. Terms that are currently used, include *delayed* language or speech, *deviant* language or speech, language *disability,* language *difficulty,* or indeed language or speech *disorder.*

PROBLEMS THAT CAN FOLLOW CATEGORICAL DESCRIPTIONS

It is true that some professionals may use terms or descriptions as though a language disorder were a diagnostic entity. In this instance, parents can, and do, interpret the description so that it is viewed as referring to a child who is just having difficulty in learning language, rather than having difficulty with language because of intellectual, sensory or emotional problems.

A particular problem that arises, is when the cause of the language difficulty is either unknown or is presumed to be neurological. If this presumption becomes widespread, it can lead to family and community pessimism, with the result that effective intervention or help is often hindered. This must be avoided.

Similarly, the terms *deviant, disordered, or disability,* may be used to refer to a child's language development that is unlike that of normal development. That is, that the child's language development is different from normal in its time of onset and rate of development as well as in the actual language skills learned and the sequence in which they are learned. Nevertheless these are terms that are used and parents need to be familiar with them if they apply to their children.

THE NEED FOR DEFINITIONS FOR BOTH PARENTS AND PROFESSIONALS

Language disorder as a diagnostic entity or as a description of qualitative differences from normal development is ultimately important for the understanding of children who have difficulty in learning language. However, such distinctions are often difficult to make. There is a need for a descriptive term that can include both quantitative and qualitative differences in language development. Parents often ask for a term which they can use in general conversation about their child's condition. Therefore, the term *language disorder* will be used in this booklet as a broad term to describe certain child language behaviours or the lack of them.

SIGNIFICANT BEHAVIOURS OF A CHILD WITH LANGUAGE DISORDER

The term *language disorder* is used as a description, in that it refers to particular behaviours observed by parents and professionals in interactive situations which normally demand talking and understanding. These behaviours include:

- no talking and much withdrawn behaviour
- little or no talking and much withdrawn behaviour
- little or no talking
- little talking and over-reliance on gesture
- much talking but it is unintelligible
- little or no understanding of instructions
- unusual use of words or phrases
- very limited vocabulary
- persistent grammatical errors in sentences so that this interferes with communication
- much talking but articulation is so impaired that the child cannot be understood.

PROBLEMS THAT CAN ARISE FOR CHILDREN WITH LANGUAGE DISORDERS

Language disorder for the intellectually handicapped or language delayed child refers to a disruption in the learning of language. As such, children with a language disorder may have:

- difficulty in learning words or phrases for representing what they know about the world
- difficulty in formulating ideas
- difficulty in understanding situations and events
- difficulty in using words or phrases that they have learned in relevant contexts
- difficulty with developing listening skills due to inappropriate or unnecessary chatter
- difficulty in interacting with their peers or with adults because of their difficulty with speaking.

The end result of these difficulties is that these children can become very *frustrated* and often *withdrawn*. As such, they can become most defensive about their difficulties with speaking and understanding language. This may result in much tension for the child, resulting in anti-social behaviour. These children require much help and understanding.

UNDERSTANDING COMPONENTS OF LANGUAGE PRIOR TO INTERVENTION

It is widely recognised that infancy and early pre-school years are critical in the development of all children. The earlier, therefore, that effective language intervention, and family support and counselling services can be introduced, the greater will be the benefit to the language disordered child. The need to understand the components of language is important, because when language disorders appear, many families can become committed to controversial programs for which great claims are made. Often the heavy financial, personal and emotional commitment of families to these controversial programs demonstrates both the extent to which families search for means of helping their children and the dearth of options open to them. There is clear evidence that timely and adequate early language intervention may forestall or prevent the need for more costly services. There is certainly evidence that a basic understanding of the components that interact to form normal language development may help parents to evaluate the language programs offered, or select those necessary to help their children. It is generally most helpful to understand just how disruptions from normal language development occur and the form that they can take. Some examples of language disorders are set out below.

DIFFERENCES FROM NORMAL DEVELOPMENT

(i) **Disorders due to developmental delay**

Developmental delay in language occurs when the form (sounds and words), the content (ideas and thoughts), and their use (relevant contexts or situations) interact quite normally but begin

(a) later than expected, or

(b) proceed slower than expected.

This means that your child uses the same forms (sounds and words) to talk of the same ideas in the same contexts and for the same purposes as the child with normal development. However, the language of the child with developmental delay appears later chronologically or after its onset, its rate of development is slower.

(ii) **Disorders of sounds and words**

Some children have an ability to represent ideas and thoughts about the world (content) and an ability to communicate these ideas in relevant situations (use). However, these children often have much difficulty in producing the correct sounds, words, phrases or sentences. As such, these children rely mainly on

(a) gesture, or

(b) sounds which have meaning for that child but for few others.

These children may also have difficulty in finding a relevant word and therefore, they talk around the idea that they are trying to communicate, e.g. they repeat words and phrases and use filled pauses such as "ums" and "ahs" in an effort to give themselves more time to find an appropriate word. The problem for these children is that their inability to produce sounds and words, or to produce the correct sounds and words, is so often very frustrating for both them and their parents. The result is often that this frustration, because of inability to produce correct sounds, may lead to disorders of ideas, or difficulty with using these ideas in relevant situations. It may also result in **refusal** to speak because these children know that others will have difficulty in understanding them, or, they may be teased by their peers and others.

(iii) **Disordered ideas and thoughts**

Some children have difficulty in the development of their ideas about the world. These children are often described as having difficulty with "conceptual development" or with expressing their ideas. For example, at the age of five or six years, they are presenting or dealing with ideas that are much more the province of a child of two or three years of age. That is, these children present the "language delay" referred to in (i) above. Alternatively, these children may have **limited ideas** and yet the words they use and the situations in which they use them far exceed the development of their ideas. For example, some children may speak in grammatically well formed sentences that appear in advance of their ideas. Children who are echolalic (they repeat verbatim what is said), or children with visual impairments (see for example, Resource Booklet No. 3, *Planning for the Visually Impaired Child*), or indeed some children with hydrocephaly, may talk a lot, but the content of what is said is often superficial and irrelevant. As such, it appears that these children often do not know the meaning of what they say. They are sometimes described as children who are "verbally aggressive". They reportedly give many commands, ask many questions, and are often very sociable. Their language seems to have an interpersonal function, but is devoid of relevant ideas.

(iv) **Disorder due to misuse or irrelevant use of context.**

Some children can produce sounds, words and ideas but they use these quite out of context. These children often ramble repetitively or they develop ideas without regard for the listener or the situation that they are in. This disorder is

most apparent when the *frequency* of the rambling, the intrapersonal (rather than interpersonal) language and the irrelevant use of language is noted. Children with this type of language disorder may appear somewhat withdrawn and rarely verbalise even if questioned or provoked. When they do speak, their language production can indicate a much greater knowledge of language and ability to speak than its general use by the child would suggest.

(v) **Disorders due to distortions of speech, ideas and situations**

This type of language disorder is best characterized by children who produce stereotyped utterances. For example, they may produce quite complex sentences which are irrelevant in the situation, or they may produce phrases and sentences which appear to have been associated with a similar situation related to some past experience. It appears that these children have learned quite complex production in response to certain situations or ideas. However, there is often a contradiction between the ideas expressed and the situation in which they are expressed, or a contradiction between the ideas and what the child actually says.

Sometimes children with this disorder may recite radio or television broadcasts without any apparent connection to external stimuli. alternatively, they may produce a phrase or expression which is only vaguely associated with he situation. Often the utterance has no apparent function other than to establish or maintain some communication contact. In these situations, the child's sound and/or sentence production, his ideas and thoughts, and the context or situation in which this language can be used, appear unrelated. It should, however, be emphasised that it is the prevalence of such a language disorder, rather than its isolated occurrence, that makes this child's language different from that of his/her peers.

LANGUAGE DISORDERS AND PREPARATIONS FOR HELPING THESE CHILDREN

The term *language disorder* has been used to describe children who have difficulty in

- producing sounds, words, phrases, sentences, or
- children who talk easily and readily but say nothing meaningful, or
- children who can talk but who talk to no-one, or
- children who talk in a most distorted manner.

Language disorders have been presented in this way because of the need for parents, teachers and speech therapists to describe accurately what children say and what they have difficulty in saying. This is necessary in order both to understand possible disruptions in the normal development of language and to plan teaching programs to help these children overcome or cope with their language disorder. Below are some Preliminary Exercises which are useful for developing children's speech.

PRELIMINARY EXERCISES FOR DEVELOPING SPEECH

1. GENERAL PHYSICAL BEHAVIOUR

In order for the language delayed child to begin to use language, his body needs to be able to express his thoughts and feelings, and his speech organs must be developed to that end.

The child must be physically capable of expanding his chest and filling his lungs with air. As his lungs collapse, the air rushes past his vocal chords producing sound. The child then converts this sound into meaningful speech and language. Proper breathing *is most important for the development of speech and language. Since the language delayed child, especially the Downs Sydrome child, is so susceptible to respiratory problems which result in a congested chest, he has potentially weak lungs and often has difficulties in breathing. Therefore it is very important to build and develop children's breathing through exercises designed to give the child practice at inhaling and exhaling. These principles apply to all language delayed children.*

Other physical activities such as sucking, swallowing, control of drooling, tongue control and chewing may have to be improved before many language delayed children can produce intelligible and meaningful speech and language.

Inhaling Exercises

1. *Have your child inhale at any desirable rate, any amount of air up to his maximum capacity. The use of a mirror for this activity may assist the child in observing (a) his chest expansion, (b) the shape of his lips, and (c) his depressed cheeks.*
2. *Your child should be encouraged to be as noisy or as quiet as he wants while inhaling.*
3. *Have your child inhale, hold his breath, and then release the air.*
4. *Have your child inhale, hold his breath, puff his cheeks, and then exhale with his cheeks puffed.*
5. *Have your child inhale as much air as he can while you count up to three, four, five.*
6. *Hold a piece of paper touching the child's lips. Have the child inhale. The paper should stay on the child's lips as long as he inhales. Try and do all these exercises yourself with your child.*

Exhaling Exercises

1. *Have your child blow candles, papers, cotton balls, and feathers.*
2. *Have your child stand or sit in front of a mirror. If he gets close enough to the mirror and blows, he will be able to see his breath marks on the mirror.*
3. *Have your child whistle: long and short, slow and fast.*
4. *Have your child blow on the back of his hand so that he may feel the force of his breath.*
5. *Have your child exhale while you count to two, three, four.*
6. *While your child exhales, have him feel and watch his abdominal (stomach) muscles.*
7. *Have a blowing contest within the family. The person who can blow the object the farthest wins. Use bubbles, balloons, table tennis balls.*
8. *When your child exhales, try to get him to produce a vowel sound: "ah,oo, ee,i."*

Sucking and Swallowing Exercises

Below are some suggestions for further developing sucking and swallowing exercises.

1. *For proper sucking and swallowing, it is important to keep the head in an upright position.*
2. *To stimulate your child to suck, compress his cheeks.*
3. *Stroking your child's throat muscles while you are compressing his cheeks will stimulate him to swallow.*
4. *Spooning of cold fluids will stimulate swallowing. Water is probably the best fluid.*
5. *If your child can feed himself with a spoon, jams and jellies will help swallowing. As your child learns to swallow, introduce thicker foods.*
6. *Lollypops can be used for rewarding and reinforcing sucking and swallowing, if you feel this will develop your child's motivation.*
7. *Have your child sip fluids through a straw.*

Drooling Control Exercises

1. *Humming, kissing, humming on a piece of paper which gives a tickle-like sensation, and lip printing on a piece of paper (put lipstick on the child's lips) are good exercises which encourage the child to close his lips. Lip printing shows the child the differences between open and closed lips.*
2. *When your child drools with his mouth open, a tap under his chin will prompt him to close his mouth.*
3. *Have your child chew like a cow in front of a mirror. Do the exercise with him.*
4. *Have your child exercise, protruding and retracting his lower jaw, to strengthen the muscles around is mouth and improve their coordination. These exercises should be done at a slower rate with Down's Syndrome child because of the generally larger size of the child's tongue.*
5. *Biting exercises for jaw closure are also important.*

Development of Tongue Control

1. *Apply pressure to your child's tongue with a blade or an icecream stick. Start at the tip of the tongue and work toward the back with a walking motion. The child's tongue will move back into his mouth automatically.*
2. *Play "Do what I do" with your child. Have your child imitate your tongue movements. Some good tongue exercises are trying to touch the nose, trying to touch the chin, moving the tongue from side to side and extending the tongue as far as possible and retracting the tongue.*
3. *have your child produce a lalling ("la, la, la") sound with an alternating slow and fast rhythm.*

Development of Chewing Exercises

1. *Have your child bite down so that he will leave an impression of his teeth on such substances as play dough.*
2. *Have your child chew toffee as vigorously as possible.*
3. *Have your child chew on a wet cloth rag or flannel so that he will suck all the water out.*

II. LOOKING AND ATTENDING BEHAVIOUR

It is important that your child be exposed to a variety of attending behaviour experiences. The training of looking and attending behaviour should begin if possible, when your child is in infancy and should be carried on indefinitely. If your child attend with the eyes, he usually is also attending with the ears.

This phase is designed to teach your child to sit quietly relaxed and to look wherever the parent or eacher directs, and also to look at the teacher prior to the presentation of any command. These attending behaviours are prerequisites for learning. It is important, therefore, that the mother or teacher pend whatever time is necessary to complete and master the task. It is felt that time well spent here will pay off well in later parts of language teaching. For example, if attention "slips" at any ime in any future task, then the parent or teacher should take the time to bring the child back to sitting still, attending and focusing before proceeding.

(a) Developing your Child's Attention

When your child looks in your direction, reward him. Use any attention-getting technique: call the child's name, clap your hands, tap on a table or piece of furniture in the direction your want him to look. Use attention-getting techniques from different parts of the room. Always remain visible. The child should be able to follow you with his eyes. If the child does not respond, get closer to him. Repeat your attention-getting techniques until the child looks. Make these exercises fun games! Reward him with enthusiastic praise whenever possible.

(b) Call Attention to your Face

Hold the child in your lap. babble, tickle, laugh with him. Take the child's had and stroke your face. Give the child a chance to rspond. Repeat your activity with the child.

(c) Use of a Mirror for Self-Discovery

Try and have a large, low-placed mirror in the room that you use for teaching. Stand or sit in front of the mirror yourself and play with your hands and face. Make sure the child is aware of what you are doing. Name parts of the body when you touch them. If the child does not approach the mirror by himself, bring him to it. Alternatively make use of a hand mirror with these self discovery activities.

Naming parts of the body — e.g. name hands. *Put your hands on the mirror, move your fingers and get your child to look at your fingers, then his fingers and his hand. When your child shows some understanding of the word* hands *(e.g. by moving his hands when you say the word), proceed in the same manner to other parts of the body: for example, nose, eyes, mouth, ears, feet. Allow your child plenty of time at the mirror.*

When your child becomes familiar with the mirror, play the game, Where is Jane's ear? Here is Jane's ear! *Point with your finger. Help your child to point with her finger.*

(d) Call Attention to Food

Do not feed the child unless he looks at the food. Be consistent. *Serve the food from different directions, thus attracting the child's attention.*

(e) Call Attention to Noisemaking Objects

If your child does not respond, encourage him by saying "Look here!" repeat your activities with different noisemakers, e.g. bell, whistle, horn, or a musical instrument only after the child has responded appropriately to one. *Do not expect immediate results. Use your child's favourite noisemaker, and use* one *noisemaker at a time.*

Ring the bell (xylophone, toy, squeaker, etc.). Pause. Give the child a chance to look. If he or she looks or attempts to look ring it again as a reward. Reward your child with praise when he or she looks.

(f) Looking and Reaching for Concealed Objects

Hold one toy within your child's reach. Get your child's attention by calling his name. If necessary, guide his hand and face toward the toy. Look for concealed objects in a box, e.g. ball, baby doll, bell, car, comb. Look for them one at a time. Say, "Show me the ball", "Put the ball in the box". "Where is the ball?" "Here is the ball". Rehearse and practise this sequence with all objects (see below, Receptive and Expressive Language Tasks).

(g) Naming Pictures and Pointing

Teach your child to point to the picture — e.g. "point to the ball", "point to the dog". Point to the picture yourself, saying its name (dog), *and ask your child to* point to the dog.

Use this technique with other dog or other cat pictures. You may of course, use pictures which include other objects in addition to dogs and cats.

Have a toy dog or toy cat or toy cow to be matched with the picture of the dog. Refer back and forth, saying "Dog — dog", "Cat — cat", "Cow — cow". A cloth or felt dog or cat for the child to feel can be most helpful. Make the dog sound — "Bow-wow", "Woof-woof", or the cat sound — "Meow-meow".

III. LISTENING BEHAVIOUR

Listening and looking tend to occur simultaneously. If your child is attending to sound, it is also likely that he is looking. In learning the sounds in his environment and the verbal speech sounds which make up language, a child must be helped and trained to listen.

Since looking and listening are so closely related in learning language, most of the activities used to train looking behaviour can also be used to train listening behaviour. Below are some additional listening exercises.

(i) Use of Mirror for Self-discovery and Listening Exercises

At the mirror have the child do the following:

Babbling — use visual sounds, /p/, /b/, /m/, /l/, /w/.

Tapping — tap finger on mouth producing sounds like "oo, ah, ee, oh".

Use the mirror as in looking, but stress listening. Have your child place his fingers on your mouth when you make the sound.

(ii) Identifying Body Parts

Name the body parts for the child, then ask the child to point to the body parts that you have named. Do not give visual clues. Rely on listening skills only.

(iii) Call Attention to Yourself

Do as in looking activities, but stress the child's listening ability. When the child responds, reward him ith praise or with other rewards that you feel are satisfactory.

(iv) Hide and Seek and Listening Behaviour

Hide a clock in the room. Ask your child to find the clock by locating the tick-tock sound. Reward your child when he finds the clock. Use other noisemaking devices to play this game. For example, hide a small radio or transportable cassette player. Reward your child when he finds them.

(v) Listening and Responding to his Name

Hold one toy within the child's reach. Get your child's attention by calling his or her name. If the child looks at you when you call his or her name, reward the child by giving him or her a toy.

IV. IMITATING

The language delayed child often loves to imitate and enjoys imitating his own actions. It is mainly for this reason that imitation can be a valuable teaching technique.

Since imitation of vocal behaviour follows imitation of motor behaviour, your child should be asked to imitate movements before he or she is asked to imitate vocal responses. Imitation, if used properly with the language delayed child, will help your child to remember and will also motivate his or her interest. Imitation can also be a form of self-expression for the child.

Details of Motor Imitation Phase

The ability to make specific motor responses, such as pointing, is necessary for successful performance in all stages of the program. Therefore those motor responses that are required of your child repeatedly throughout the program are taught, if necessary. Please notice that what is being taught are specific imitative responses deemed prerequisites for successful performance in later phases of teaching, i.e. a generalised imitative repertoire is not the immediate objects.

A Plan for Specific Imitation

Imitative behaviour to be learned is set out below. In a random sequence, including two or more trials in each item, the parent presents the following models to the child, accompanied by the command, DO THIS.

1. *The parent points to an object on the table, one finger.*
2. *The parent extends both hands in front of him.*
3. *The parent points to his eyes, one with each forefinger.*
4. *The parent points to his nose, one finger.*
5. *The parent taps his upper front teeth, one finger.*
6. *The parent places one hand lightly on the top of his head, palm down.*
7. *The parent points to his ears, one with each forefinger.*
8. *The parent stands up.*
9. *The parent sits down.*
10. *The parent points to a light, with a forefinger.*
11. *The parent combs his hair.*
12. *The parent washes his hands.*
13. *The parent washes his face.*
14. *The parent wipes his nose.*

An Example of Motor Imitation and Rewarding Your Child's Behaviour

(i) When your child crawls, crawl with him or her.

(ii) When your child claps his or her hands or pounds the table, do the same. The child needs the reinforcement and the encouragement of his or her own behaviour by himself or herself and others.

(iii) When your child throws the ball, runs after it, or chases you, cooperate and imitate his or her way of playing.

(iv) Imitate the sounds made by your child. By doing this you stimulate, reinforce, and motivate your child in his or her activities. Make it a fun game. Apply affection and pleasure to your voice to leave the child with a pleasant association.

(v) Gradually vary the sounds your child practises. Introduce sounds that can be used later to represent the people who are doing the training (such as mama, dada).

If your child has been babbling and stops suddenly, use this silent moment to attract his or her attention and repeat the child's former vocalization. When this is done, it helps maintain your child's interest.

Training

The following is an example of a training session on specific motor imitation.

1. **Teaching**. *The parent teaches those behaviours outlined above until mastery has been achieved. The parent presents the behaviour to be imitated, learned and mastered by the command DO THIS. For example, the parent may say DO THIS, and point to an object on the table. If the child responds correctly by pointing to the object he is reinforced (rewarded). If the child does not respond or responds incorrectly, the parent may use physical assistance, such as guiding the child's hand towards the object, after which the child is immediately reinforced/rewarded. The parent continues to reinforce successive approximations to the desired imitative response, gradually withdrawing physical assistance and gestural prompts until the child imitates without help the parent's pointing to the object. Training trials on the new behaviour are interspersed with trials on behaviours already learned. When your child can complete the task without error, then a new behaviour to be imitated may be added.*

2. **Parent Testing**. *The parent randomly presents those behaviours (two or three trials on each) that the child has imitated correctly. If your child's responses are 90 per cent correct on your randomized test, the parent teaches the child a new imitative behaviour.*

Preparatory Tasks Check List

Thirty activities are listed below. All of these tasks are considered to be an aid to the development of speech and language. Mastery in all of these activities is desirable and should be rehearsed. However, note that failure to achieve mastery in these tasks should not stop you from tasks in the receptive and expressive areas.

		Mastery
1.	Follows moving object with eyes	Correct response
2.	Stops movement in response to sounds	"
3.	Makes "startled" movement in response to sound	"
4.	Turns toward the source of sound	"
5.	Focuses on one object for 30 seconds	For 30 seconds
6.	Moves mouth, chews food and swallows	Correct response
7.	Reaches for objects — shows eye-hand co-ordination	"
8.	Points or gestures towards the objects he wants	"
9.	Fixes eyes on and retrieves a rolling ball	"
10.	Throws objects	
11.	Pushes and pulls objects	"
12.	Uses hands to grasp objects (and shows preferences)	"
13.	Picks up objcts in palm of hand	"
14.	Picks up objects with fingers	"
15.	Places objects such as cubes in containers	"
16.	Places objects, e.g. pegs in holes	"
17.	Places blocks to make vertical/horizontal structures	"
18.	Turns pages of book	"
19.	Makes marks, e.g. spontaneous scribble using preferred hand	"
20.	Makes controlled stroke with crayon or pencil	"
21.	Sits still for up to one minute	"
22.	Pays attention to your face for 30 seconds	"
23.	Listens to music for one minute	"
24.	Listens to spoken voice for one minute	"
25.	Imitation skills — crawling	"
26.	Imitation skills — clapping	"
27	Imitation skills — waves "bye-bye"	"
28.	Looks attentively at three random objects when presented individually	"
29.	Looks attentively at five random objects when presented individually	"
30.	Makes speech sounds — e.g. vocalizes two different sounds	"

Teaching a child comprehension and expressive language skills requires careful planning and sequencing of tasks. These tasks appear in the draft language manual "Parents as Language Therapists" written by the author and published by Canberra C.A.E. They are to be developed and illustrated in a future publications project by the Curriculum Development Centre.

EXPRESSIVE LANGUAGE : LEARNING TO SPEAK

It is this phase that parents are generally most keen to reach. However, remember that: (a) this expressive or speaking phase is necessarily preceded by the acquisition of receptive or comprehension language skills and that (b) correct articulation will take a long time to acquire. To begin with consistently recognisable imitation *of words is a realistic goal.*

Development of Articulation Skills: Making Sounds

Articulating the sounds of our language depends on the child's ability to manipulate the organs of speech in (i) a variety of different movements, and (ii) by making a variety of different shapes, so that these different movements and shapes will produce the sounds that surround the child in his environment.

Children will start learning to imitate speech early in the first year of life. For example while the baby is still crying or babbling he moves his tongue and lips. As he does this he discovers that the sounds he makes are changed by these movements. After experimenting in making different movements and trying to copy the sounds that he hears, the child will gradually associate these sounds and noises with certain positions, movements and feelings of tension in his speech organs. Children will try to imitate the sounds made by their parents. When they recognise their noises as imitation, parents should applaud their efforts. This careful praise will encourage children to try even harder. By attending to and praising certain sounds and ignoring others, parents select the speech sounds that their children are encouraged to practise.

Babbling

Babble gives babies and language delayed children practice in experimenting with a variety of sounds. Many of these sounds can be producted fortuitously by changing the child's body position. For example, babies lying on their back with their tongues slumped against the soft palate almost automatically produce many /k/ and /ch/ (as in loch) sounds. Later, even before a baby gains head control his or her lips make easy contact and the babble includes a high proportion of /pl/, /b/ and /m/ sounds. Also all sorts of vowel sounds /a/, /e/, /i/, etc. can be produced. Once the child has established head control then tongue tip sounds could be produced. However, some problems with vocal imitation may occur for the language delayed child and these are now detailed.

Problems Encountered in Vocal Imitation and Vocal Expression

There are two problems which can thwart the parent in teaching vocal imitation and vocal expression. These are:

(a) stereotyped vocal responses
(b) echolalia

Stereotyped vocal responses *means that your child utters only one unchanging vocal response on all occasions. When this occurs, the sound, the accompanying facial expression and indeed, the inflectual patterns are essentially identical. This must be tackled so that your child soon acquires many vocal responses. We suggest that you take note of the exercises for imitating mouth positions — see below ways to produce new sounds.*

Echolalia. *This is generally defined as* repetitive language behaviour *such that the child reiterates more or less automatically words and phrases that he hears.*

In the development of speech (expressive thought), (a) the parent or teacher states the question very softly *and then states the desired verbal response very* loudly, *(b) the parent or teacher then repeats the question softly and omits the answer — for example, in naming objects, the parent whispers "WHAT IS THIS?" and then says loudly "BUS", (c) the parent or teacher then repeats the question* softly *and waits for the child to answer. When your child repeats only the desired verbal response, he is reinforced (rewarded) with praise and if necessary, sweets or other edibles.*

As soon as possible, the parent or teacher says only the question, requiring the child to supply the correct verbal response. This procedure can be used in all expressive tasks.

Commonly Imitated Sounds: The sequence of sounds

When your child starts trying to imitate those around him, the simple made lip sounds of b *and* m *are related to the most simply made sounds. For example some babies try tongue tip sounds first, mainly* d *and* n. *Therefore the first words to be acquired should be duplications of simply made mouth movements like dada, nana, baba, mama. A child developing speech normally should begin to say these words at ten months but this will be achieved later for the language delayed child. Single consonant vowel syllable such as baw = ball, ca = car, or do = dog should follow sounds made by simple mouth movements. Later the child should be able to duplicate the first syllable in imitating two-syllabled words such as ho-ho = hotter, pe-pe = pen or wa-va = water. It will then take more months of practice for the child to manage his speech movements quickly enough to change the second syllable as in mu-mmy or da-ddy or bu-nny. Later still the child learns to end words with a consonant so that "doggies" becomes "dog", "horsie" becomes "horse", "birdie" becomes "bird", or indeed "mummy" becomes "mum"!*

Learning individual sounds

It is estimated that in most languages there are about forty different speech sounds. Children have to learn these. For example, vowels acquire the humping or lowering of different parts of the tongue and with practice the language delayed child should be able to produce vowel sounds. Some of the consonants already described are easy to make but others are more difficult. Therefore it will take the child longer to learn to make /s/, /l/, /r/ and /th/ sounds than of course /b/, /m/ or /p/ sounds.

The ability to articulate correctly depends not only on the child's growing ability to control the movements of his speech organs but also on his ability to discriminate between sounds that are similar. In order to learn to articulate words in imitation of those he hears the child must be able to:

(a) discriminate *the form of each sound*
(b) remember *the sequence of the sounds*
(c) control *and* co-ordinate *the movement of the speech organs and so ..... make sounds into words.*

Ways to produce new sounds

Differences in sounds have little bearing on a child's language unless associated with differences in meaning. Therefore the parent, teacher or speech therapist should look out for confusions that occur. This is important because many children with receptive speech difficulties need training in recognising the order *as well as the differences of sounds, syllables and words. The order of sounds can be focused on by breaking up words into single sounds or syllables. The accurate production of sounds is always of concern to parents, teachers and speech therapists. Means by which children can learn to produce new sounds are:*

(i) Imitation of the parent, teacher or therapist's mouth position as a sound is made.
(ii) Motor kinaesthesis: the parent, teacher or therapist actually manipulates the child's tongue or lips into a position that makes it easy for the child to produce the sound.
(iii) Imitation of a sound on its own.
(iv) Phonetic placement: the parent, teacher or therapist tells *the child what to do with his lips and tongue and cheeks in order to produce the sound.*
(v) Juxtaposition: the parent, teacher or therapist makes the child's tongue move very *slightly in a particular direction or in a certain manner just after saying a well established sound. For example, this method is commonly used for producing an* s *preceding a* t *as in "station" or an* s *following a* t *as in "hats".*
(vi) Contraposition: the parent, teacher or therapist makes the child's tongue change its position entirely. For example, tongue on hard palate to a rolling position for producing k *(c) before* l *as in "climb".*

It is important to realise that once a sound has been achieved much practice *is needed by the child to learn to produce the sound at the speed of normal speech. It may take many months to establish each new sound in a child's speech. However, it is usual for a child to be working on a number of different sounds at the same time. For example, the child could practice "babbling" with one sound, ear training (listening skills) with another sound, word and/or phrase repetition on another.*

Articulation Difficulties

Although there are many ways that misarticulations can be characterised, the most frequently used system categorizes articulation errors into four categories: (i) substitutions, (ii) omissions, (iii) distortions, (iv) additions.

Substitutions *Substitution errors can occur when a child produces a speech sound belonging to one phoneme in place of another phoneme. For example the child who says /f/ for /th/ as in throw or/w/ for /r/ as in ran or /b/ for /v/ as in van, or /b/ for /v/ as in very or /d/ for /th/ as in this. It is reported that substitutions are eight to ten times more common than omissions especially among children under eight years of age. Substitutions occur most frequently in the initial position of words.*

Omissions *Omissions are those errors in which a speech sound is not produced. This of course is a common problem among young children. For example the child who says "I ea i cream" for "I eat ice cream" reveals several omission errors. Omissions are found most frequently in the final position of words. They also occur frequently in the context of consonantal blends, for example, "ceam" for "cream" in which the /r/ is omitted — or "pate" for "plate" in which the /l/ is omitted.*

Distortions *Distortions are error sounds that are not sufficiently like any standard speech sound of the child's language to be considered substitutions. One common form of distortion is the lateral lisp in which the air stream is directed over the lateral teeth in one or both sides of the mouth rather than directed by a central groove formed with the tongue across the upper gum ridge and over the central incisors. Sounds such as /s/, /sh/, /z/ and /ch/ are sounds that can be distorted by children experiencing difficulties. In contrast with substitutions which typically decrease in both absolute and relative frequency as children become older, distortions constitute an increasing proportion of the total articulation errors as a child's age increases.*

Additions *Additions are rather uncommon errors even among language delayed children. However, they do occur. In some instances a vowel may be added to what otherwise might be a consonant blend, thus breaking the blend into two syllables, such as "cuhlimb" for "climb" or "buhrake" for "brake" or "tuhrain" for "train". There is also the condition in which a child adds a vowel to a final consonant in a word. For example "car" or "ball" would be produced as two consonant-vowel syllables, "cara" or "balla". In both cases the additions alter the syllabic form of the words. In these cases the child's phonology and/or motor system may only permit syllables of particular forms.*

PROBLEMS OF CORRECT ARTICULATION IN TEACHING

Throughout the expressive or spoken tasks set out above the parent or teacher must remember that perfect articulation is not required. Any approximation to the correct response that your child utters is reinforced (rewarded), provided parents or teachers are able to discriminate among the different responses being made. If parents are unable to discriminate between two utterances, one of the items should be dropped until a better approximation of the other can be established. For example, if the child's production of the (ee) sound in *me*, and *eat*, is a more or less identical (i (ee)), drop the word *eat* until *me* is more clearly articulated and understood.

The ability of the parent or teacher to guide the child to closer and closer approximations of correct articulation as the child moves through the expressive tasks is likely to be highly variable. Parents and teachers will need to be patient — speak slowly and clearly and above all, *praise* the child's efforts. it is important to remember that punishment for failure supresses trying. Much improvement is likely to occur with *sustained repetition* of the basic vocabulary. This will help develop the child's memory. If the child inadvertently becomes upset in any part of this difficult period of the spoken tasks, then return to a previously mastered receptive activity and try to terminate the teaching for the day on a happy and successful note.

CHILDREN WITH SPECIAL LANGUAGE DIFFICULTIES

The preliminary exercises, comprehension and expressive language tasks could be accomplished by most language delayed children. However, there are some children who may have particular difficulties. For example:

(a) Children who stammer
(b) Children with Cleft Palate
(c) Children with Cerebral Palsy
(d) Intellectually Handicapped Children
(e) Emotionally Disturbed Children

The difficulties that these children have are now examined.

(a) CHILDREN WHO STAMMER

It is not known what causes stammering in spite of numerous investigations. However, conditions most commonly associated with stammering include:

(1) Family history of stammering
(2) Late or poor talking
(3) Inco-ordination, clumsiness and over-activity, right/left confusion

Circumstances that commonly increase stammering include

(1) Communicative responsibility, e.g. when a complicated message has to be reproduced orally.
(2) When information has to be given verbatim with no possible alternatives, e.g. when giving name, address, telephone number.
(3) When speaking to someone in authority.
(4) When the child is excited.
(5) When the child feels guilty.
(6) When the child has to attend to speech.

Circumstances that commonly reduce stammering

(1) Speaking when alone.
(2) Speaking in unison with other children.
(3) Singing.
(4) Speaking to babies or animals.
(5) Speaking to someone regarded as inferior.
(6) Speaking in a rhythm. Here the child learns a rhythm of stressing.
(7) Speaking at a **slow** speed — here syllables can be enunciated regularly in syllables with equal stress.
(8) Speaking when relaxed and calm.

Stammering occurs more frequently in children whose desire to communicate is strongly developed but their ability to articulate clearly, to select the necessary correct words and to construct sentences are still at a rudimentary stage.

It is not possible to make many general statements about stammering because there is such a great deal of variation in the situations that cause an individual to stammer. However, each stammering child needs a full examination of his intelligence, language development (along similar lines to that of the child with a language disorder), and school achievements. He should have a paediatric-neurological examination, particularly with reference to his motor co-ordination and his right/left orientation. His emotional and social development and adjustment need to be carefully considered, remembering that a child, particularly an older one who has grown up with a stammer, has often become a little withdrawn and more self-conscious than usual about meeting new people. Young children do not, as a rule, recognise that they have a stammer, but the struggle and frustration experienced while attempting to communicate make it hardly possible for the child to remain unaware of it beyond the age of seven or eight. Even then many children are reluctant to ask for or accept help — they feel they can "get by" much of the time and that the stammer will go away by itself. They would not mind being helped but are unwilling to work hard at changing their speech pattern, which they seem to regard as something highly personal. About the age of twelve their attitude often changes and they will probably ask for help.

It is of primary importance to find out about the family relationships as possible causes of anxiety and tension which can cause the young child to persist in stammering and make it more severe. One starts by asking the parents about how the various members of the family react to the child's stammering. Parents often express their impatience with the child who cannot say quickly what he wants and sometimes they complain, "He doesn't even **try** to stop it." Most parents do their level best to show sympathy and understanding, but it is natural that when they are busy or in a hurry they come to the limits of their endurance at times with this impediment. Discussing the family's attitude to the child's stammer leads on to talking of attitudes to other situations and causes of tension may be revealed and ultimately reduced.

(b) CHILDREN WITH CLEFT PALATE

It is estimated that about one in every 700 babies in Australia is born with a cleft palate. A palate cleft is the result of the **lack** of complete fusion of the two sides of the mouth when the baby is still growing in the mother's womb. The cleft may affect the lip only or the palate only or, most commonly, both lip and palate. The cleft may be covered by a layer of mucous membrane and only a split uvula give evidence of the underlying cleft palate (Renfrew, 1972). This last condition (a sub-mucous cleft) is not usually discovered till the child is brought to the doctor or speech therapist to find out why he or she has a nasal tone in speech.

When at birth the cleft is found to be complete, i.e. through lip, alveolus (upper gum) and hard and soft palates, it is usual for the orthodontist to fit the baby with a dental plate to anchor the two sides of the alveolus and gradually bring them together. When the surgeon repairs the cleft in the lip, this closing of the lip gap further moulds the alveolus into a smoother rounded symmetry. Later, any time from six months old, the palate is repaired. Some surgeons complete their work on the palate in one operation by repairing both hard and soft palates. Other surgeons repair only the soft palate and allow the hard palate to grow without interference until the child is five or six on the principle that surgical interference can cause disturbance to the growth centres in the middle of the face. In Renfrew's experience no special advantage in facial development has yet been seen as a result of leaving the hard palate open until six years (Renfrew, 1972).

The child who has had only a lip cleft seldom suffers from a speech defect due to this problem. A very few have trouble with the lip sounds /p/, /b/, /m/ and articulate these with the lower lip contacting the upper teeth. If the soft palate only is cleft, speech difficulty is usually avoided if the "gap at the back" can be repaired.

The cleft palate child's speech is affected by

(i) Difficulties of voice due to the gap at the back
(ii) Difficulties of articulation due to the twist at the front.

Nowadays most children born with cleft palates are treated by surgery within the first year or eighteen months of life. It seems that the earlier the operation can be performed, the better the eventual speech result. If the cleft is restricted to the soft and hard palates and does not interfere with the gum and tooth ridge, results are particularly good unless some other factor such as deafness or intellectual handicap complicates the picture. Children with a complete cleft through soft and hard palates, upper gum and lip have a little more trouble and take more time to learn to speak clearly because of the misshapen arch within which the tongue has to operate in making the shapes necessary for speech sounds.

Speech therapy for the child with the cleft palate requires an individual prescription. Four out of five children who have expert surgical treatment for the cleft when under two years of age develop normal vocal tone. The fifth child is usually either deaf, severely intellectually handicapped or suffering from brain damage. Sometimes, for no obvious reason, surgery is unsuccessful.

(c) CHILDREN WITH CEREBRAL PALSY

This term is used to cover a number of different disorders resulting from brain damage. Their most striking features are paralysis, inco-ordination and uncontrollable involuntary movements. However, most children with cerebral palsy suffer also from sensory and perceptual dysfunctions.

The best-known types are spasticity, athetosis, rigidity and ataxia. Frequently two or more types are present — or become present — in the same child.

At least 70% of children with cerebral palsy suffer from speech difficulties. In mild cases they present as a slurred and slow articulation, lacking the usual sentence rhythms, yet are quite intelligible if one concentrates on listening to it and becomes familiar with its rate and odd rhythm. In other cases the difficulty is so severe that they are unable to communicate through speech. These children will need to be taught a sign language.

Hearing Problems

About 20% of children with cerebral palsy suffer from a hearing loss with high tone loss particularly prevalent amongst athetoids. So it is essential that, despite the difficulties of carrying out a satisfactory hearing test on cerebral palsied children, attempts should be made to do so in the hope of assessing the child's degree of handicap in hearing.

The cerebral palsied child who is totally or even partially deaf will have greater or less difficulty in discriminating and understanding speech and in consequence his production of speech will reflect his distorted reception of it. It also should be noted that a large proportion of cerebral palsied children suffer from sensory and perceptual disturbances.

As noted above the speech of the cerebral palsied is often difficult to understand. However, it may not actually be the defective articulation that makes the speech of the cerebral palsied child difficult to understand, but the disturbance of its rhythmic production. This is to a large extent accounted for by their irregularity of breathing due to lacking either the normal respiratory regulating functions, or the neuromuscular control of the breathing mechanism producing inco-ordination between their thoracic, diaphragmatic and abdominal muscles (see above Preliminary Exercises for developing speech).

The breathing of the cerebral palsied child must be carefully examined; its regularity in quiet breathing and its input-output ratio when speaking; its depth; the thoracic, diaphragmatic and abdominal movement. This information will help parents and others to understand why the child has difficulty in speaking.

Indifferent breathing and distortion of sound

The result of inco-ordination of breathing muscles and their lack of synchronisation with the voice and speech movements in larynx, pharynx and mouth is that a sound that should be articulated in one-eighteenth of a second can be prolonged to almost one second and so distort the pronunciation of the word as to make it unintelligible. Sentences are constantly broken up by the loss of breath control rather than by the sense pauses.

The cerebral palsied child presents a complicated condition. There are many manifestations and symptoms and it is impossible to make generalizations.

A cerebral palsied child with slow speech development or speech that is difficult to understand should be under the care of a speech therapist or pre-school teacher from the age at which his speech difficulty is first noticed.

(d) INTELLECTUALLY HANDICAPPED CHILDREN

This term covers a wide range of slow and limited development of the brain from children who can be educated in small classes using special methods to those very profoundly handicapped children who are never able to learn to look after themselves in washing, dressing or feeding.

Examination of the speech difficulties of these intellectually handicapped children reveals that their speech is generally not likely to be further developed than that of a child of the same **mental** age, i.e. if the five-year-old Down's Syndrome child is two years old mentally, his speech could not be expected, although it sometimes is, to be more than single words and some two-word phrases, or in some instances, simple sentences.

However, many intellectually handicapped children do not function in speech up to the level of their mental age judged by their performance on non-verbal intelligence tests. In some cases their articulation still remains at an infantile level when they are ten years old or more. More frequently their whole language development is retarded, vocabulary is small, sentence construction incomplete. They may have extreme difficulty in formulating in speech even the simple ideas in their mind. A child will sometimes chatter away repetitively with a sort of vocal clammering to get attention and people will conclude that his speech is "all right" when actually it is only his articulation that matches up to normal standards.

However, there is much evidence that highly structured teaching programs similar to the one outlined in this booklet can improve these children's comprehension and speech. However, it should be noted that

(a) the number of words in their vocabulary is small
(b) their development of concepts is poor and therefore they can misunderstand the meanings of words used in everyday conversation
(c) the memory for what they hear is short in span and often their attention is poor so that by the time they have decoded the first part of a sentence, they often have much difficulty in remembering the second part.

Well-meant advice is sometimes given to parents of intellectually handicapped children, as well as to parents of other children with speech difficulties, along the lines of "talk to him all the time. Never lose a chance to explain things to him. Keep reading to him", and so on. Mothers complain, naturally enough, of being exhausted when carrying out this advice and seeing little results for all their efforts. Intellectually handicapped children in particular should **not** be bombarded with talk for, having difficulty decoding quickly what they hear, they must "shut their ears" to conserve the use of their limited mental functions. Much structure in the teaching of them is required. This structure is an aid to the development of memory and ultimately speech and language.

Use of Picture Books and Outside Activities

Picture books are a great help for developing understanding and use of speech in all children especially in the intellectually and physically handicapped whose experience of everyday situations is restricted. These books should, however, be carefully chosen to give the child practice at the stage he has reached or is about to reach. For the younger children, **one** object per open page is enough. In imitation of the mother the child learns the names of the objects. See receptive and expressive exercises above.

The intellectually handicapped child is greatly helped if he can regularly go out and about with his family shopping, visiting and on all sorts of expeditions where he can hear and, to the best of his ability, take part in the conversation about what is going on around them, the social chatter, the summaries of past events and plans for future ones. This will help the skills he has acquired in classroom or clinic teaching to generalize.

The company of other children of his own age or younger gives the child an opportunity to practise his speech where demands are not high. He needs, too, the experience of getting along with his contemporaries in an atmosphere where his limitations are accepted. Any integration of the intellectually handicapped in a named school would help to develop their speech if it is carefully planned.

(e) EMOTIONALLY DISTURBED CHILDREN

There are few children who have difficulty with speech who are without some degree of emotional instability. They are either unduly shy and retiring, difficult to make contact with, obsessional or aggressive, demanding, lacking in concentration and so on. The families, too, seem to have more than the average share of troubles. It is difficult to sort out how far the child's speech defect is caused by these problems or how far the child's emotional and social growth has been hampered or disturbed by his difficulties in communicating. In many cases several factors are operating internally and externally to hinder the child's improvement.

The child's need to listen and talk is stimulated by having close relationships early in life with **one** particular person, normally the mother. To relate well one must have an efficient means of communication, and this is developed through speech.

Difficulties arise in cases where the parents are withdrawn or silent people. Then the child has few cues to help him detect parents' feelings towards him or even give him the information he needs to understand the world around him. Other parents are often so talkative that the child's attempts to communicate are ignored because parents are so intent on expressing themselves. In both cases the child is handicapped through lack of practice due to lack of stimulation.

Children from families whose main source of speech is rebukes, commands, expostulations and expletives do not think of speech in any pleasurable sense, indeed they may fear it. It is important to realise that these children have little incentive to learn to listen or to talk.

If the mother has a poor relationship with her child, communication will be affected by it and the child's willingness to listen and to talk will be restricted. Therefore, unless he has another outlet like a loving father or older sibling to talk with, language development will be slower than usual. However, careful counselling of the family can be most helpful in these cases.

Sometimes the teacher or speech therapist can help in these cases by providing the "other outlet" or helping the mother to make a better relationship with her child, but on the whole, such a case is usually referred to the Child Guidance Clinic or Counselling Services.

Depression

Just as many adults, when depressed or extremely worried, cannot bear to talk about their troubles, so do children react under such circumstances. They are often regarded as merely surly or stupid when answering "I don't know" to questions regarding their personal life. This reluctance to talk can affect all communications so that the child may refuse to answer questions on any subject. When this withdrawal becomes so marked that the child cannot bring himself to talk to people at all, counselling or psychotherapy may be needed.

Some childen never have an opporunity for making close relationships. They may be carefully reared in a material sense in a well-equipped residential nursery, but are looked after by an ever-changing number of adults with none of whom do they spend long enough to get to know well. Consequently communication has little point apart from the conveying of a small amount of necessary information. These children become retarded in their speech development, particularly if they have an introverted nature. They live in a world of their pictorial imagination. The teacher or speech therapist can do much for such children both by developing as close a relationship as possible and also by ensuring that the child's horizons are enlarged through contacts with ordinary families and the development of friendship with peers.

RELATIONSHIPS WITH OTHER CHILDREN AND ADULTS

Some children are born with, or in infancy show marked signs of having, no ability to make human relationships. They show no response to their mother when she is caring for them, do not react normally to physical contacts and will behave erratically to speech or other noises. They may at the usual time of speech development start using merely vocal play.

It is most difficult in some cases to decide whether the child is deaf or not, as he may not react even to loud sounds. Sometimes he will show that he has been startled by an unusual noise, but repeating the noise produces no other response from him. It can be shown by highly specialised forms of hearing tests that in many cases sound is being transmitted through the outer ear at least as far as the lower centres of the brain, yet this sort of child behaves as though he were deaf. However, some similar children who do not develop speech show that they understand speech and react to it quite normally.

Many children with these characteristics will use a small stereotyped phrase repeatedly, see above p. 13, some to get attention, others for vocal play. Some will be docile and follow around like a puppy; others are obsessional in their behaviour, engrossed in their body movements or fascinated with such things as keys, locks and doors; others still are difficult to control because of their hyperactivity. It is possible through carefully structured programs such as the one advocated in this booklet to teach these children communication skills or indeed to talk. However, careful planning and persistence is required.

OTHER A.P.A. EARLY CHILDHOOD RESOURCE BOOKLETS AVAILABLE

1978	No. 1	CHILDREN LEARN THROUGH EXPERIENCE
	No. 2	AN A.B.C. OF CHILDREN'S NEEDS
	No. 3	A READING LIST FOR PARENTS
	No. 4	SERVICES FOR THE YOUNG HANDICAPPED CHILD
	No. 5	WHERE, WHAT, WHEN – A DESCRIPTION OF SERVIES FOR CHILDREN
1979	No. 1	AUSTRALIAN EXPERIENCES WITH PLANTS AND ANIMALS
	No. 2	SHARING OUR DIFFERENCES: DEVELOPING A MULTI-CULTURAL PROGRAM
	No. 3	PLANNING FOR THE VISUALLY IMPAIRED CHILD
	No. 4	BABIES LEARN FROM BIRTH – THE FIRST YEAR
	No. 5	BABIES LEARN FROM BIRTH – THE SECOND AND THIRD YEARS
1980	No. 1	THE PLAYGROUND – AN OUTDOOR ENVIRONMENT
	No. 2	MOVEMENT EDUCATION FOR YOUNG CHILDREN
	No. 3	PARENTS AND TEACHERS TOGETHER – FOR CHILDREN

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